Outpatient Speech Therapy Fee-For-Service Policy and Billing Manual

Provider Qualifications

Providers must be enrolled as a Health First Colorado (Colorado's Medicaid Program) provider in order to:

- Treat a Health First Colorado member
- Submit claims for payment to the Health First Colorado

Eligible Providers

Eligible providers may be individual practitioners or may be employed by home care agencies, children's developmental service agencies, health departments, Federally Qualified Health Centers (FQHC), clinics, or hospital outpatient facilities. The provider agency or the individual provider must verify that rendering providers meet the following qualifications:

Speech-language Pathologists (SLPs, speech therapists) must have a current certification by the Colorado Department of Regulatory Agencies (DORA) pursuant to the Speech-language Pathology Practice Act.

Speech-language Pathology Assistants are support personnel who, following academic and/or on-the-job training, perform tasks prescribed, directed, and supervised by DORA-certified speech-language pathologists. Speech-language pathologists must follow the ASHA guidelines on the training, use, and supervision of assistants. **Speech-language pathology assistants** must practice under the general supervision of a Colorado registered speech-language pathologist.

- Speech-language pathology assistants cannot enroll with Health First Colorado and therefore cannot place any identifying number on a claim form. Therefore, the supervising therapist's NPI must be used as the **rendering provider** on the claim form for services rendered by the assistant.

Clinical Fellows, practicing under the general supervision of a DORA-certified speech-language pathologist may provide speech therapy services.

- Clinical Fellows cannot enroll with Health First Colorado and therefore cannot place any identifying number on a claim form. Therefore, the supervising therapist's NPI must be used as the rendering provider on the claim form for services rendered by the Clinical Fellow.

Therapy may also be rendered by licensed and enrolled physicians, physician assistants, and advanced practice nurses as allowed by their respective scopes of practice.

All providers must submit a completed provider enrollment to become a Health First Colorado provider. Providers will find enrollment information on the Provider Revalidation & Enrollment web page..

General Benefit Policies

Speech therapists not employed by an agency, clinic, hospital, or physician may bill Health First Colorado directly, otherwise it is the employer who bills directly for the services. Providers should refer to the Code of Colorado Regulations, Qualified Non-Physician Practitioners Eligible to Provide Physician's Services (10 CCR 2505-10, Section 8.200.2.C), for further regulatory information when providing speech therapy.

1. All Outpatient Speech Therapy services must have a written order/prescription/referral by any of the following:
    a. Physician (M.D. or D.O.)
    b. Physician Assistant
    c. Nurse Practitioner
    d. An approved Individualized Family Service Plan (IFSP) for Early Intervention Speech Therapy. (Senate bill 07-004 states the IFSP "shall qualify as meeting the standard for medically necessary services." Therefore no physician is required to sign a work order for the IFSP.)

2. Pursuant to the Affordable Care Act's requirements that State Medicaid Agencies ensure correct ordering, prescribing, and referring (OPR) National Provider Identification (NPI) numbers be on the claim form (42 CFR §455.440):
    a. All Outpatient Speech Therapy claims must contain the valid NPI number of the Ordering, Prescribing, Rendering (OPR) physician, physician assistant, nurse practitioner, or provider associated with an Individualized Family Service Plan (IFSP), in accordance with Program Rule 8.125.8.A.
        i. Community Centered Boards may have their NPI listed as the referring NPI for IFSP-ordered early intervention services.

    b. All physicians, physician assistants, nurse practitioners, or providers associated with an IFSP who order, prescribe, or refer Outpatient Speech Therapy services for Health First Colorado members must be enrolled in Health First Colorado (42 CFR §455.410), in accordance with Program Rule 8.125.7.D. OPR Providers can begin enrollment on Health First Colorado's website.
        i. The new enrollment requirement for OPR providers does not include a requirement to see Health First Colorado members or to be listed as a Health First Colorado provider for member assignments or referrals.
        ii. Physicians or other eligible professionals who are already enrolled in Health First Colorado as participating providers and who submit claims to Health First Colorado are not required to enroll separately as OPR providers.

3. The term "valid OPR NPI number" means the registered NPI number of the provider that legitimately orders, prescribes, or refers the Outpatient Speech Therapy service being rendered, as indicated by the procedure code on the claim.
    a. Claims without a valid OPR NPI number which are paid will then be subject to recovery.
    b. Medical documentation must be kept on file to substantiate the order, prescription, or referral for Outpatient Speech Therapy. Claims lacking such documentation on file will be subject to recovery.

4. Health First Colorado recognizes that Outpatient Speech Therapy ordered in conjunction with an approved IFSP for Early Intervention may not necessarily have an ordering provider. Under this circumstance alone the rendering provider must use their own NPI number as the OPR NPI number.
    a. Early Intervention Outpatient Speech Therapy claims must have modifier 'TL' attached on the procedure line item for Health First Colorado to identify that the services rendered were associated with an approved IFSP.
        i. Any claim with modifier 'TL' attached must be for a service ordered by an approved IFSP and delivered within the time span noted in the IFSP.
        ii. If the OPR NPI on the claim is that of the rendering provider, and the claim does not have modifier 'TL' attached, the claim is subject to recovery.

5. Therapies provided as part of a member's individualized education program (IEP) by a therapist in the school setting are not separately reimbursable. These services are paid for by the school district which is reimbursed by the Department. Providers may not submit claims for services performed in the school setting. Refer to the School Health Services Program page for details.

6. The term "Outpatient" means any therapy which is **not** performed in an Inpatient Hospital or School setting, or by a Home Health Agency.

7. Speech-language pathologists not employed by an agency, clinic, hospital, school district, or physician may bill Health First Colorado directly. Providers should refer to the Code of Colorado Regulations, Qualified Non-Physician Practitioners Eligible to Provide Physician's Services (10 CCR 2505-10, Section 8.2003.C), for specific information when providing speech therapy.

Payment for Covered Services

Regardless of whether Health First Colorado has actually reimbursed the provider, billing members for covered services is strictly prohibited. Balance billing is prohibited. If reimbursement is made, providers must accept this payment as *payment in full* (see Program Rule 8.012). The provider may only bill the member for services **not** covered by Health First Colorado.

1. Members may be billed for non-covered services in accordance with C.R.S. 25.5-4- 301(1)(a)(I).
    - (1) (a) (I) Except as provided in section 25.5-4-302 and subparagraph (III) of this paragraph (a), no recipient or estate of the recipient shall be liable for the cost or the cost remaining after payment by Medicaid, Medicare, or a private insurer of medical benefits authorized by Title XIX of the social security act, by this title, or by rules promulgated by the state board, which benefits are rendered to the recipient by a provider of medical services authorized to render such service in the state of Colorado, except those contributions required pursuant to section 25.5-4-209 (1). However, a recipient may enter into a documented agreement with a provider under which the recipient agrees to pay for items or services that are non-reimbursable under the medical assistance program. Under these circumstances, a recipient is liable for the cost of such services and items.
2. If Prior Authorization Requests (PAR) for services are required, the following policy applies:
    - Technical/lack of information (LOI) denial does not mean those services are not covered. Members may not be billed for services denied for LOI.
    - Services partially approved are still considered covered services. Members may not be billed for the denied portion of the request.
    - Services totally denied for not meeting medical necessity criteria are considered non-covered services.

Medically Necessary

Outpatient speech therapy services must be medically necessary to qualify for Health First Colorado reimbursement. Medical necessity (10 CCR 2505-10 8.076.1.8) means a Medical Assistance program good or service:

a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.

b. Is provided in accordance with generally accepted professional standards for health care in the United States;

c. Is clinically appropriate in terms of type, frequency, extent, site, and duration;

d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider;

e. Is delivered in the most appropriate setting(s) required by the client's condition;

f. Is not experimental or investigational; and

g. Is not more costly than other equally effective treatment options.

Documentation Requirements

Rendering providers must document all evaluations, re-evaluations, services provided, client progress, attendance records, and discharge plans. All documentation must be kept in the client's records along with a copy of the referral or prescribing provider's order. Documentation must support both the medical necessity of services and the need for the level of skill provided. Rendering providers must copy the client's primary care provider (PCP), prescribing provider and/or medical home on all relevant records.

All documentation must include the following:

1. The client's name and date of birth
2. The date and type of service provided to the client
3. A description of each service provided during the encounter including procedure codes and time spent on each (including start and stop times)
4. The total duration of the encounter
5. The name or names and titles of the persons providing each service and the name and title of the therapist supervising or directing the services.

Health First Colorado requires the following types of documentation as a record of services provided within an episode of care: initial evaluation, re-evaluation, visit/encounter notes and a discharge summary.

Initial Evaluation

Written documentation of the initial evaluation must include the following:

1. **Referral Information**: Reason for referral and referral source.
2. **History**: Must include diagnoses pertinent to the reason for referral, including date of onset; cognitive, emotional, and/or physical loss necessitating referral, and the date of onset, if different from the onset of the relevant diagnoses; current functional limitation or disability as a result of the above loss, and the onset of the disability; pre-morbid functional status, including any pre-existing loss or disabilities; review of available test results; review of previous therapies/interventions for the presenting diagnoses, and the functional changes (or lack thereof) as a result of previous therapies or interventions.
3. **Assessment**: The assessment section must include a summary of the client's impairments, functional limitations and disabilities, based on a synthesis of all data/findings gathered from the evaluation procedures. Pertinent factors which influence the treatment diagnosis and prognosis must be highlighted, and the inter-relationship between the diagnoses and disabilities for which the referral was made must be discussed.
4. **Plan of Care**: A detailed Plan of Care must be included in the documentation of an initial evaluation. This care plan must include the following:

    a. Specific treatment goals for the entire episode of care which are functionally-based and objectively measured
    b. Proposed interventions/treatments to be provided during the episode of care
    c. Proposed duration and frequency of services to be provided

d. Estimated duration of episode of care.

- An episode of outpatient therapy is defined as the period of time from the first day the client is under the care of the clinician for the current condition(s) being treated by one therapy discipline until the last date of service for that plan of care for that discipline in that setting.
- The therapist's plan of care must be reviewed, revised if necessary, and signed, as medically necessary by the client's physician, or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 90 days.
- The care plan may not cover more than a 90-day period, or the time frame documented in the approved IFSP.
- A plan of care must be certified. Certification is the physician's, physician's assistant or nurse practitioner's approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. If the service is a Medicare covered service and is provided to a client who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare.

Re-Evaluation

A re-evaluation must occur whenever there is an unanticipated change in the client's status, a failure to respond to interventions as expected or there is a need for a new plan of care based on new problems and goals requiring a significant modification of treatment plan. The documentation for a re-evaluation need not be as comprehensive as the initial evaluation, but must include at least the following:

1. Reason for re-evaluation
2. Client's health and functional status reflecting any changes
3. Findings from any repeated or new examination elements
4. Changes to plan of care

Visit/Encounter Notes

Written documentation of each encounter must be in the client's record of service. These visit notes document the implementation of the plan of care established by the therapist at the initial evaluation. Each visit note must include the following:

1. The total duration of the encounter.
2. The type and scope of treatment provided, including procedure codes and modifiers used.
3. The time spent providing each service, including the start and stop times. The number of units billed/requested must match the documentation. In the case of untimed billing codes, such as 92507, documentation must clearly show exactly how much time was spent performing that service.
4. Identification of the short or long-term goals being addressed during the encounter.

5. Note Format:

   Documentation must follow the Subjective, Objective, Assessment and Plan (SOAP) format. In addition to the above required information, the visit note should include:
   a. A subjective element which includes the reason for the visit, the client or caregiver's report of current status relative to treatment goals, and any changes in client's status since the last visit;
   b. An objective element which includes the practitioner's findings, including abnormal and pertinent normal findings from any procedures or tests performed;
   c. An assessment component which includes the practitioner's assessment of the client's response to interventions provided, specific progress made toward treatment goals, and any factors affecting the intervention or progression of goals; and
   d. A plan component which states the plan for next visit(s).

Discharge Summary

At the conclusion of therapy services, a discharge summary must be included in the documentation of the final visit in an episode of care. This must include the following:

1. Highlights of a client's progress or lack of progress towards treatment goals.
2. Summary of the outcome of services provided during the episode of care.

Record Retention

Providers must maintain records that fully disclose the nature and extent of services provided. Upon request, providers must furnish information about payments claimed for Colorado Medical Assistance Program services. Records must substantiate submitted claim information. Such records include but are not limited to:

1. Treatment plans
2. Prior authorization requests
3. Medical records and service reports
4. Records and original invoices for items, including drugs that are prescribed, ordered, or furnished
5. Claims, billings, and records of Colorado Medical Assistance Program payments and amounts received from other payers

- Each provider shall retain any other records created in the regular operation of business that relate to the type and extent of goods and services provided (for example, superbills).
- All records must be legible, verifiable, and must comply with generally accepted accounting principles and auditing standards (10 CCR 2505-10 8.130.2.E).
- Each entry in a medical record must be signed and dated by the individual providing the medical service. Stamped signatures are not acceptable (10 CCR 2505-10 8.130.2.F).
- Providers utilizing electronic-record keeping may apply computerized signatures and dates to the medical record if their record-keeping systems guarantee the following security measures:
  - Restrict application of an electronic signature to the specific individual identified by

the signature. System security must prevent one person from signing another person's name.

- Prevent alterations to authenticated (signed and dated) reports. If the provider chooses to supplement a previous entry, the system must only allow a new entry that explains the supplement. The provider cannot be allowed to change the initial entry.

Printed or displayed electronic records must note that signatures and dates have been applied electronically (10 CCR 2505-10 8.130.2.G.).

Covered Services

Assessment

Service may include testing and/or clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas, and must yield a written evaluation report.

1. Expressive language.
2. Receptive language.
3. Cognition.
4. Augmentative and alternative communication.
5. Voice disorder.
6. Resonance patterns.
7. Articulation/phonological development.
8. Pragmatic language.
9. Fluency.
10. Feeding and swallowing.
11. Hearing status based on pass/fail criteria.
12. Motor speech.
13. Aural rehabilitation (defined by provider's scope of practice).

Treatment

Service may include one or more of the following, as appropriate:

1. Articulation/phonological therapy.
2. Language therapy including expressive, receptive, and pragmatic language.
3. Augmentative and alternative communication therapy. Adults with chronic conditions may qualify for augmentative and alternative communication services when justified and supported by medical necessity to allow the individual to achieve or maintain maximum functional communication for performance of Activities of Daily Living.
4. Auditory processing/discrimination therapy.
5. Fluency therapy.
6. Voice therapy.
7. Oral motor therapy.
8. Swallowing therapy.
9. Speech reading.
10. Cognitive treatment.
11. Necessary supplies and equipment.
12. Aural rehabilitation (defined by provider's scope of practice).

Rehabilitative Speech Therapy

In accordance with 10 CCR 2505-10 8.200.3.D.2.d.i, Rehabilitative speech therapy is a covered benefit under the following conditions. "Rehabilitative" means therapy that treats acute injuries and illnesses which are non-chronic conditions. Rehabilitative is therefore short-term in nature.

1. Adult Policy
    a. All Health First Colorado members age 21 and over may receive Rehabilitative speech therapy to treat non-chronic conditions and acute illness and injury.
2. Child Policy
    a. All Health First Colorado members age 20 and under may receive Rehabilitative speech therapy to treat non-chronic conditions and acute illness and injury.
3. The acute condition must be documented in all medical/treatment session notes, and must be accompanied by an order/referral/prescription by a licensed Health First Colorado enrolled physician, physician assistant, or nurse practitioner.

Habilitative Speech Therapy

In accordance with 10 CCR 2505-10 8.017.B, Habilitative speech therapy is a covered benefit under the following conditions. The Colorado Division of Insurance has defined "Habilitative" services to be:

> Services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado's Essential Health Benefits benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration.

"Habilitative" means therapy that treats chronic conditions with the purpose of helping the member retain or improve skills and functioning that are affected by the chronic condition. Habilitative therapy may therefore be long-term in nature.

1. Adult Policy
    a. All Health First Colorado members ages 21 and over are considered adults. Only adults who are on the Alternative Benefit Plan (ABP), the ACA Adult Health First Colorado Benefit Plan, may receive Habilitative speech therapy.
        i. When checking a member's ID in the eligibility portal, adult expansion members will have the coverage of "ABP – Alternative Benefit Plan" listed in the coverage details box. Eligible members may receive outpatient PT, OT, and ST for the purposes of habilitation in addition to rehabilitation.
        ii. If the adult member **only** has the benefit coverage of "TXIX – Medicaid State Plan", they are not eligible for Habilitative speech therapy services.
    b. The member's chronic condition must be documented in all medical/treatment session notes, as well as in the Prior Authorization Request, and must be accompanied by an order/referral/prescription by a licensed Health First Colorado enrolled physician, physician assistant, or nurse practitioner.
    c. Eligible members may receive Habilitative speech therapy in addition to Rehabilitative speech therapy so long as the therapies are not duplicative and rendered on the same date of service.

2. Child Policy
    a. All Health First Colorado members ages 20 and under may receive Habilitative speech therapy to treat a chronic condition which requires ongoing speech therapy to prevent against the loss of functional ability.
    b. The chronic condition must be documented in all medical/treatment session notes and must be accompanied by an order/referral/prescription by a licensed Health First Colorado enrolled physician, physician assistant, or nurse practitioner.
    c. Eligible members may receive Habilitative speech therapy in addition to Rehabilitative speech therapy so long as the therapies are not duplicative and rendered on the same date of service.

Additional Notes

- Habilitative therapies are not categorized as an Inpatient or Home Health benefit. 'Acute' and 'Long-term' therapies remain benefits per Home Health coverage.
- Habilitative therapies are not categorized as a benefit if provided in nursing facilities; Rehabilitative speech therapy remain a benefit in that setting.
- Habilitative therapies should not to be confused with Habilitation services found within Home and Community Based Services (HCBS) waivers

Non-Covered Services

1. Health First Colorado does not cover items and services which generally enhance the personal comfort of the eligible person but are not necessary in the diagnosis of, do not contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member.
2. Maintenance programs beginning when the therapeutic goals of a treatment plan have been achieved and no further functional progress is apparent or expected to occur, are not covered for adult clients.
3. Services provided without a written referral from a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law are not covered, unless they are covered by an Individual Family Service Plan (IFSP).
4. Treatment of speech and language delays not associated with an acquired or chronic medical condition, neurological disorder, acute illness, injury, or congenital defect are not covered, unless they are covered by an IFSP.
5. Any service that is not determined by the provider to be medically necessary according to the definition of medical necessity in this document is not covered.
6. Services not documented in the client's health care record are not covered.
7. Services not part of the client's plan of care are not covered.
8. Services specified in a plan of care that is **not** reviewed and revised as medically necessary by the client's physician (M.D. or D.O.), physician's assistant, nurse practitioner, or specified in an approved IFSP for Early Intervention speech therapy are not covered.

9. Art and craft activities for the purposes of recreation are not covered.
10. Services which are experimental, investigational, or are provided as part of a clinical trial are not covered. Hippotherapy/equine therapy is considered experimental and is not covered.
11. Supplies or pre-fabricated supplies that can be obtained from a medical supplier are not covered.
12. Services for conditions of chronic pain that do not interfere with the client's functional status and that can be treated by routine nursing measures are not covered.
13. Services that are not designed to improve or maintain the functional status of a recipient with a physical loss or a cognitive or psychological deficit are not covered.
14. A therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements is not covered.
15. Vocational or educational services, except as provided under IEP-related or waiver services are not covered.
16. Services provided by unsupervised therapy assistants as defined by the American Speech-Language Hearing Association (ASHA) are not covered.
17. Treatment for dysfunction that is self-correcting (for example, natural dysfluency or developmental articulation errors) is not covered.
18. Psychosocial services are not covered.
19. Educational, personal need and comfort therapies are not covered.
20. Record keeping documentation and travel time (the transport and waiting time of a client to and from therapy sessions) is not reimbursable.
21. Time spent for preparation, report writing, processing of claims, or documentation regarding billing or service provision is not reimbursable.
22. Therapy that replicates services that are provided concurrently by another type of therapy is not covered. Particularly, occupational therapy which should provide different treatment goals, plans, and therapeutic modalities from speech therapy.

Assistive Technology Assessments

The following billing policies are effective for CPT procedure code **97755** to accommodate HB14-1211. HB14-1211 requires that all Health First Colorado members seeking complex rehabilitation technology must have an initial Assistive Technology Assessment (complex rehabilitative technology evaluation/assessment) prior to receiving complex rehabilitation technology, and follow-up assessments, as needed. Only licensed speech, physical, and occupational therapists may render this specialty evaluation.

All providers using procedure code **97755** must follow these guidelines. The Department recognizes that only a portion of Assistive Technology Assessments will be used for complex rehabilitation technology evaluation/assessment. Providers will be asked upon PAR submission if the service is for a complex rehabilitation technology assessment.

Policy	Notes
Complex rehabilitation technology evaluations / assessments are billed using only 97755.	Combinations of procedure codes, including procedure code 97542, for the purposes of complex rehabilitation technology evaluation / assessment are not allowed.
97755 always requires a Prior Authorization Request (PAR).	PARs must be submitted electronically using ColoradoPAR. Details are found here.
Member daily limit of 97755 is 20 units.	Up to five hours of assessment is allowed per date of service.
Member yearly limit of 97755 is 60 units.	Members may have up to 60 units of procedure code 97755 per State Fiscal Year (July 1 – June 30). This limit will reset with the start of each new State Fiscal Year.

PARs for 97755 must comply with the following policies:

1. Must have a current prescription/referral for an Assistive Technology Assessment from the member's primary care physician.
2. May indicate up to one year duration.
3. May indicate initial/new assessments or follow-up assessment visits.
4. Only one active PAR for 97755 is allowed per member, per span of time. Overlapping 97755 PAR requests will be denied.
5. Initial speech therapy evaluation services, such as 92521, are not required prior to requesting 97755.
6. 97755 is separate from physical and occupational therapy (PT/OT) and is not part of the PT/OT benefit limitation.
7. PARs for 97755 should be submitted independently from other services. The Medical PAR type should be selected for 97755 at ColoradoPAR.com.

97755 performed by a Speech Therapist is considered Rehabilitative speech therapy and is covered for both adults and children.

If a member requires further assessment by a different provider not indicated on the original PAR, and that PAR is still active, then it must be closed by the original requesting provider. Once closed a new PAR can be submitted. Members may request a 'change of provider' on their PAR by contacting the vender directly. Please see the Prior Authorization Request section of this manual.

Benefit Limitations

1. Eligible members may not receive both Rehabilitative and Habilitative speech therapy services on the same date of service.
2. Speech Therapy is limited to five (5) units of service per date of service. Some specific daily limits per procedure code apply. Please see the table below.

a. While a maximum of five units of service is allowed per date of service, providers are required to consult the American Medical Association's (AMA) Current Procedural Terminology (CPT) manual for each coded service. Some codes represent a treatment session without regard to its length of time (one unit maximum) while other codes may be billed incrementally as "timed" units.

3. Members determined to need a speech generating device (HCPCS codes E2500, E2502, E2504, E2510, E2211, E2512, and E2599) should be referred to a Health First Colorado participating medical supplier to be prior authorized.
4. All claims must meet eligibility and claim submission requirements (e.g. timely filing, third party resources payment pursued, required attachments included, etc.) before payment can be made.

Coding Tables

Allowed Place of Service Codes

The following place of service codes are allowed:

Place of Service (POS) Code	Description
02	Telemedicine *(see Telemedicine billing manual)*
03	School - *(non-public) services provided in or during public school must be billed by the school district only*
11	Office
12	Home
99	Other – *(Community Based Organization)*

- Speech therapy services provided at an Outpatient Hospital are reported on the institutional claim type and are reimbursed as part of the hospital's EAPG payment. Institutional claim types do not have the POS code field.
- Speech therapy services provided at a Federally Qualified Health Center (FQHC) are billed as part of the encounter rate for the FQHC. They are not billed separately on professional claims.
- Rule allows for speech therapy services to be rendered at a location of "Community Based Organization". Since there is no exact POS code which aligns with this description, POS code 99 should be reported.
- NCCI MUE edits stipulate maximum daily units for each code. Reference the NCCI website for further information.
- Providers should reference official AMA CPT resources for full descriptions of codes and instruction for proper use.

Required Billing and PAR Modifiers

Outpatient Therapy Type	Modifier 1	Modifier 2
Rehabilitative Speech Therapy	GN	97
Habilitative Speech Therapy	GN	96
Early Intervention Speech Therapy	GN	TL

Allowed Outpatient Speech Therapy Procedure Codes

Procedure Code	Unit Limits Max # units per member, per provider, per DOS	Prior Authorization Required
92521	NCCI MUE value	No
92522	NCCI MUE value	No
92523	NCCI MUE value	No
92524	NCCI MUE value	No
92507	NCCI MUE Value	**Yes**
92508	NCCI MUE Value	**Yes**
92520	NCCI MUE Value	No
92526	NCCI MUE Value	**Yes**
92597	NCCI MUE Value	No
92605	NCCI MUE Value	No
92606	NCCI MUE Value	No
92607	NCCI MUE Value	No
92608	NCCI MUE Value	No
92609	NCCI MUE Value	**Yes**
92610	NCCI MUE Value	No
92611	NCCI MUE Value	No
92612	NCCI MUE Value	No
92614	NCCI MUE Value	No
92626	NCCI MUE Value	No

92627	NCCI MUE Value	No
96105	NCCI MUE Value	No
96111	NCCI MUE Value	No
G0515	NCCI MUE Value	No
97755	20 per day, 60 per fiscal year	Always
Q3014	NCCI MUE Value	No

National Correct Coding Initiative (NCCI)

National Correct Coding Initiative Procedure-To-Procedure (PTP) and Medically Unlikely Edits (MUE) edits apply to certain combinations of speech therapy procedure codes. Please refer to the Medicaid.gov website on NCCI edits for the NCCI Policy Manual, a complete list of impacted codes, guidance on bypass modifier use, and general information.

Policy guidance for NCCI provided in this manual does not supersede Federal NCCI policy. It is published to assist providers in understanding how the Health First Colorado Speech Therapy benefit is affected by NCCI edits and policy.

Although every effort is made to guide providers accordingly, this manual may not always reflect the most up to date NCCI policies, nor is it an exhaustive list of any edit/policy that may affect the speech therapy benefit. Providers should always reference the Medicaid.gov website for the most current NCCI policies as those policies may change.

Health First Colorado does not create NCCI policy.

All providers are required to comply with NCCI policy.

Pursuant to the NCCI Policy Manual (Current Revision 1-1-2019, Chapter XI – Page 13):

- Speech language pathologists may perform services coded as CPT codes **92507**, **92508**, or **92526**. They do not perform services coded as CPT codes **97110**, **97112**, **97150**, or **97530** or **G0515**, which are generally performed by physical or occupational therapists. Speech language pathologists shall not report HCPCS/CPT codes **97110**, **97112**, **97150**, **97530**, **97127** or **G0515** as unbundled services included in the services coded as **92507**, **92508**, or **92526**. (CPT code 97532 was deleted on January 1, 2018.)
- A single practitioner should not report CPT codes **92507** (treatment of speech, language, voice . . .; individual) and/or **92508** (treatment of speech, language, voice . . .; group) on the same date of service as HCPCS/CPT codes **97127** (therapeutic interventions that focus on cognitive function…), or **97533** (sensory integrative techniques to enhance . . .), or G0515 (development of cognitive skills to improve…).
- However, if the two types of services are performed by different types of practitioners on the same date of service, they may be reported separately by a single billing entity. For example, if a speech language pathologist performs the procedures described by CPT codes

92507 and/or **92508** on the same date of service that an occupational therapist performs the procedures described by HCPCS/CPT codes **97127**, **97533** and/or G0515, a provider entity that employs both types of practitioners may report both services utilizing an NCCI PTP-associated modifier. (CPT code 97532 was deleted on January 1, 2018.)

- Treatment of swallowing dysfunction and/or oral function for feeding (CPT code **92526**) may utilize electrical stimulation. The HCPCS code **G0283** (electrical stimulation (unattended), to one or more areas for indication(s) other than wound care...) should not be reported with CPT code **92526** for electrical stimulation during the procedure. The NCCI PTP edit (**92526**/**G0283**) for practitioner service claims does not allow use of NCCI PTP-associated modifiers with this edit because the same provider would never perform both of these services on the same date of service. However, the same edit for outpatient hospital facility claims does allow use of NCCI PTP-associated modifiers because two separate practitioners in the same outpatient hospital facility or institutional therapy provider might perform the two procedures for different purposes at different member encounters on the same date of service.

Billing Information

Refer to the General Provider Information manual for general billing information.

Prior Authorization Requests (PARs)

Independent speech therapists and outpatient hospital based therapy clinics providing outpatient speech therapy must submit, and have approved, PARs for medically necessary services prior to rendering the services.

Prior Authorization Requests are approved for up to a 6-month period (depending on medical necessity determined by the authorizing agency).

- Retroactive PAR requests will be accepted for children ages 0-3 who are under the direction of the Early Intervention program. Retro-authorization requests will be approved for a window of 30 calendar days from the start date of the approved IFSP. This policy is meant to accommodate the periods of service coordination between IFSPs.
    - For example, an EI provider may submit a PAR retroactively on May 15th for an IFSP which began April 22nd.
    - However, claims will not be reimbursed until there is an approved PAR on file for the services requested.
- Overlapping PAR request dates for same provider types will not be accepted.
- Incomplete, incorrect or insufficient member information on a PAR request form will not be accepted.

Submit PARs for the number of units for each specific procedure code requested, not for the number of services. Modifiers **must** be included on both the PAR and claim submission. When submitting a PAR for either rehabilitative or habilitative services, the procedure codes must include GN + 96/97 modifiers (e.g. 92507+GN+97).

PAR Requests Must Include:

- Legibly written and signed ordering practitioner prescription, to include diagnosis (preferably with ICD-10 code) and reason for therapy, the number of requested therapy sessions per week and total duration of therapy.
- The member's speech therapy treatment history, including current assessment and treatment. Include duration of previous treatment and treating diagnosis.
- Documentation indicating if the member has received PT or OT under the Home Health Program or inpatient hospital treatment.
- Current treatment diagnosis.
- Course of treatment, measurable goals and reasonable expectation of completed treatment.
- Documentation supporting medical necessity for the course and duration of treatment being requested.
- Assessment or progress notes submitted for documentation, must not be more than sixty (60) days prior to submission of PAR request.
- If the PAR is submitted for services delivered by an independent therapist, the name and address of the individual therapist providing the treatment must be present in field #24 of the PAR.
- The billing provider name and address needs to be present in field #25 on the PAR.
- The Health First Colorado provider number of the independent therapist must be present in PAR field #28.
- The billing provider's Health First Colorado number must be present in field #29 of the PAR.
- The authorizing agency reviews all completed PARs and approves or denies, by individual line item, each requested service or supply listed on the PAR. PAR status inquiries can be made through the Provider Web Portal and results are included in PAR letters sent to both the provider and the member. **Read the results carefully as some line items may be approved and others denied. Do not render or bill for services until the PAR has been processed.**
- The claim must contain the PAR number for payment.

Approval of a PAR does not guarantee Health First Colorado payment and does not serve as a timely filing waiver. Prior authorization only assures that the service is considered a benefit of the Health First Colorado. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g. timely filing, third party resources payment pursued, required attachments included, etc.) before payment can be made.

If the PAR is denied, providers should direct inquiries to the authorizing agency, located on the Provider Contact page of the Department website.

The Health First Colorado PAR forms are available on the Provider Forms web page or by contacting the ColoradoPAR Program at 888-801-9355 (toll free).

CMS 1500 Paper Claim Reference Table

The following paper form reference table shows required, optional, and conditional fields and detailed field completion instructions for the CMS 1500 claim form.

Reference the Electronic Claims section of the General Provider Information manual for more information on electronic billing.

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Health First Colorado seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's** Name	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's** Date of Birth **/ Sex**	Required	Enter the member's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070115 for July 1, 2015. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's full last name, first name, and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
5	**Patient's Address**	Not Required	
6	**Patient's Relationship** to Insured	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.
7	**Insured's Address**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
8	**Reserved for NUCC Use**		
9	**Other Insured's Name**	Conditional	If field 11d is marked "YES", enter the insured's last name, first name and middle initial.
9a	**Other Insured's Policy or Group Number**	Conditional	If field 11d is marked "YES", enter the policy or group number.
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Conditional	If field 11d is marked "YES", enter the insurance plan or program name.
10a-c	**Is Patient's Condition Related to?**	Conditional	When appropriate, place an "X" in the correct box to indicate whether one or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.

CMS Field #	Field Label	Field is?	Instructions
11a	**Insured's Date of Birth, Sex**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015. Place an "X" in the appropriate box to indicate the sex of the insured.
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another Health Benefit Plan?**	Conditional	When appropriate, place an "X" in the correct box. If marked "YES", complete 9, 9a and 9d.
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Conditional	Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015. Enter the applicable qualifier to identify which date is being reported 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period
15	**Other Date**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Conditional	
17.b	**NPI of referring physician**	Required	Required in accordance with Program Rule 8.125.8.A
18	**Hospitalization Dates Related to Current Service**	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Conditional	
20	**Outside Lab?** **$ Charges**	Not Required	
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for adjusted claims. When resubmitting a claim as a replacement or a void, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim

CMS Field #	Field Label	Field is?	Instructions
			8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Not Required	
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).
24A	**Dates of Service**	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010116 for January 1, 2016 From To **01 01 16** | | | | | | Or From To **01 01 16 01 01 16** Span dates of service From To **01 01 16 01 31 16** Single Date of Service: Enter the six digit date of service in the "From" field. Completion of the "To field is not required. Do not spread the date entry across the two fields. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates. **Supplemental Qualifier**

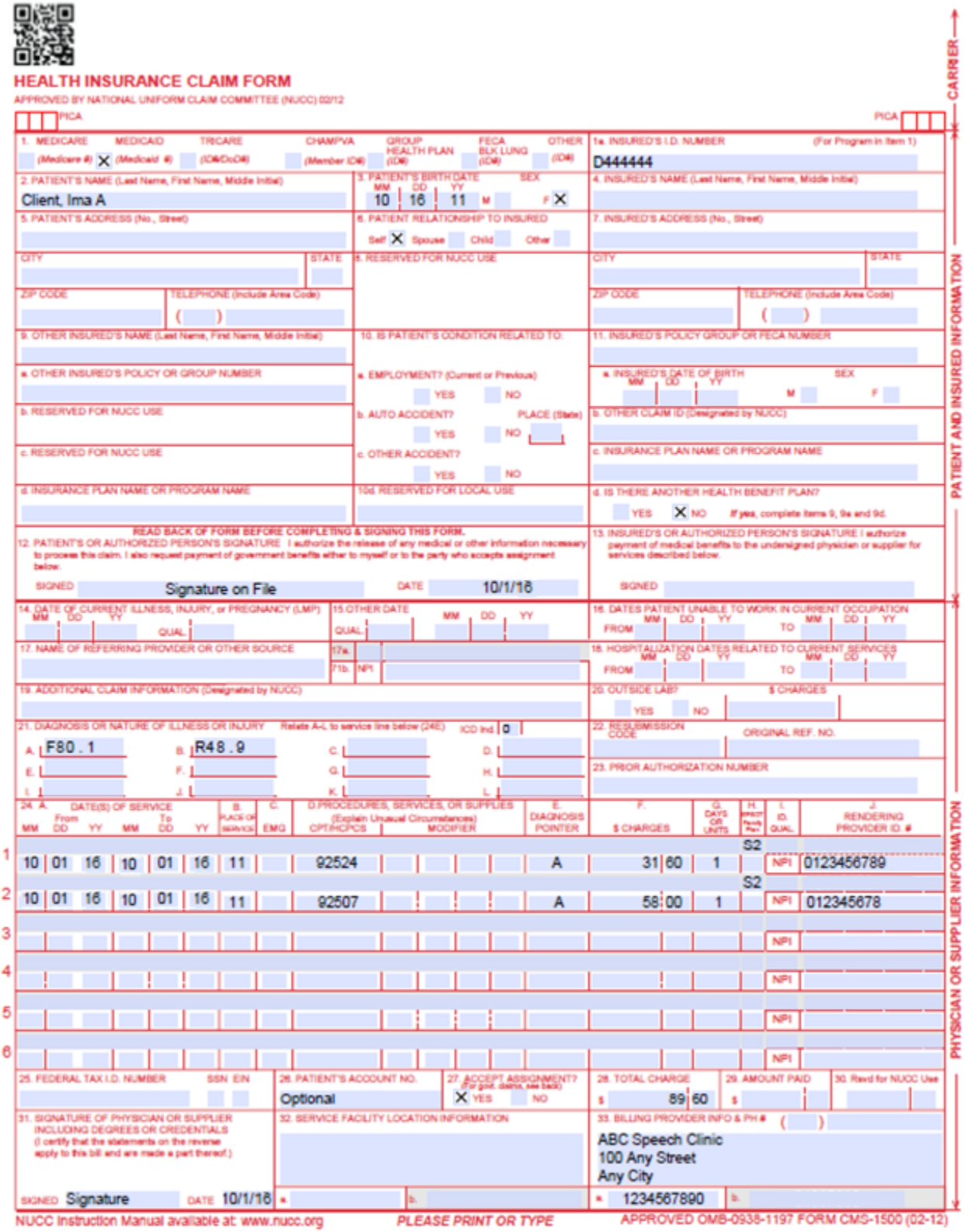
CMS Field #	Field Label	Field is?	Instructions
			To enter supplemental information, begin at 24A by entering the qualifier and then the information. ZZ Narrative description of unspecified code N4 National Drug Codes VP Vendor Product Number OZ Product Number CTR Contract Rate JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Health First Colorado accepts the CMS place of service codes. *See manual's section on allowed place of service codes.*
24C	**EMG**	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually. HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only). Only approved codes from the current CPT or HCPCS publications will be accepted.
24D	**Modifier**	Required	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form.

CMS Field #	Field Label	Field is?	Instructions
			See manual's section on required billing modifiers.
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.
24F	$ **Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Health First Colorado covered individuals for the same service. Do not deduct Health First Colorado co-payment or commercial insurance payments from the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.

CMS Field #	Field Label	Field is?	Instructions
24H	**EPSDT/Family Plan**	Conditional	**EPSDT** (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used **Family Planning** (unshaded area) Not Required
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Required	In the shaded portion of the field, enter the NPI of the Health First Colorado provider number assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	**Total Charge**	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.

CMS Field #	Field Label	Field is?	Instructions
30	**Rsvd for NUCC Use**		
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used. An authorized agent or representative may sign the claim for the enrolled provider. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070116 for July 1, 2016. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Facility Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known).
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider

CMS 1500 Speech Therapy Claim Example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE MM DD YY: 10 16 11 SEX M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M | F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES | NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE: 10/1/16

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. F80.1 B. R48.9 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 16	10 01 16	11		92524		A	31 60	1	S2	NPI 0123456789
2	10 01 16	10 01 16	11		92507		A	58 00	1	S2	NPI 012345678
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 89 60

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature DATE 10/1/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Speech Clinic
100 Any Street
Any City

a. 1234567890 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

UB-04 Paper Claim Reference Table

Speech therapy outpatient hospital paper claims must be submitted on the UB-04 claim form.

The information in the following table provides instructions for completing Form Locators (FL) as they appear on the UB-04 paper claim form. Instructions for completing the UB-04 claim form are based on the current *National Uniform Billing Committee (NUBC) UB-04 Reference Manual*. Unless otherwise noted, all data FLs on the UB-04 have the same attributes (specifications) for the Health First Colorado as those indicated in the *NUBC UB-04 Reference Manual*.

All code values listed in the *NUBC UB-04 Reference Manual* for each FL **may not** be used for submitting paper claims to the Health First Colorado. The appropriate code values listed in this manual must be used when billing the Health First Colorado.

The UB-04 certification must be completed and attached to all claims submitted on the UB-04. A copy of the certification form is included with this manual. Completed UB-04 paper Health First Colorado claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A.

Do not submit "continuation" claims. Each claim form has a set number of billing lines available for completion. Do not crowd more lines on the form. Billing lines in excess of the designated number are not processed or acknowledged. Claims with more than one page may be submitted electronically.

The Paper Claim Reference Table below lists the required, optional and/or conditional form locators for submitting the UB-04 paper claim form to Health First Colorado for speech therapy services.

Reference the Electronic Claims section of this manual for more information on electronic billing.

Form Locator and Label	Completion Format	Instructions
1. Billing Provider Name, Address, Telephone Number	Text	Required Enter the provider or agency name and complete mailing address of the provider who is billing for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.
2. Pay-to Name, Address, City, State	Text	Required if different from FL 1. Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services: Street/Post Office box City

Form Locator and Label	Completion Format	Instructions
		State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	Optional Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
3b. Medical Record Number	17 digits	Optional Enter the number assigned to the member to assist in retrieval of medical records.
4. Type of Bill	3 digits	Required Enter the three digit number indicating the specific type of bill. The three digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency): **Digit 1** — **Type of Facility** 1 Hospital 2 Skilled Nursing Facility 3 Home Health 4 Religious Non-Medical Health Care Institution Hospital Inpatient 5 Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services 6 Intermediate Care 7 Clinic (Rural Health/FQHC/Dialysis Center) 8 Special Facility (Hospice, RTCs) **Digit 2** — **Bill Classification (Except clinics & special facilities):** 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)

Form Locator and Label	Completion Format	Instructions
		5 Intermediate Care Level I 6 Intermediate Care Level II 7 Sub-Acute Inpatient (revenue code 19X required with this bill type) 8 Swing Beds 9 Other **Digit 2** **Bill Classification (Clinics Only):** 1 Rural Health/FQHC 2 Hospital Based or Independent Renal Dialysis Center 3 Freestanding 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (CORFs) 6 Community Mental Health Center **Digit 2** **Bill Classification (Special Facilities Only):** 1 Hospice (Non-Hospital Based) 2 Hospice (Hospital Based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 5 Critical Access Hospital 6 Residential Facility **Digit 3** **Frequency:** 00 Non-Payment/Zero Claim 01 Admit through discharge claim 02 Interim - First claim 03 Interim - Continuous claim 04 Interim - Last claim 07 Replacement of prior claim 08 Void of prior claim

Form Locator and Label	Completion Format	Instructions
5. Federal Tax Number	None	Not required Submitted information is not entered into the claim processing system.
6. Statement Covers Period – From/Through	From: 6 digits MMDDYY Through: 6 digits MMDDYY	Required (**Note:** OP claims cannot span over a month's end) Enter the From (beginning) date and Through (ending) date of service covered by this bill. *Example:* 01012016 = January 1, 2016 This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete FL 45 (Service Date). Providers not wishing to span bill following these guidelines, must submit one claim per date of service. "From" and "Through" dates must be the same. All line item entries must represent the same date of service.
8a. Patient Identifier		Not required Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required Enter the member's last name, first name and middle initial.
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the member's street/post office box as determined at the time of admission.
9b. Patient Address – City	Text	Required Enter the member's city as determined at the time of admission.
9c. Patient Address – State	Text	Required Enter the member's state as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the member's zip code as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Optional

Form Locator and Label	Completion Format	Instructions
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the member's birthdate using two digits for the month, two digits for the date, and four digits for the year. *Example*: 01012015 = January 1, 2015
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the member's sex.
12. Admission Date	6 digits	Conditional Required for observation holding beds only
13. Admission Hour	6 digits	Conditional Required for observation holding beds only
14. Admission Type	1 digit	Required Enter the following to identify the admission priority: **1 – Emergency** Member requires immediate intervention as a result of severe, life threatening or potentially disabling conditions. Exempts inpatient hospital & clinic claims from co-payment and PCP referral. Exempts outpatient hospital claims from co-payment and PCP only if revenue code 450 or 459 is present. This is the only benefit service for an undocumented alien. If span billing, emergency services cannot be included in the span bill and must be billed separately from other outpatient services. **2 - Urgent** The member requires immediate attention for the care and treatment of a physical or mental disorder. **3 - Elective** The member's condition permits adequate time to schedule the availability of accommodations. **4 - Newborn** Required for inpatient and outpatient hospital. **5 - Trauma Center** Visit to a trauma center/hospital as licensed or designated by the state or local government authority

Form Locator and Label	Completion Format	Instructions
		authorized to do so, or as verified by the American College of Surgeons and involving trauma activation. **Clinics** Required only for emergency visit.
15. Source of Admission	1 digit	Required Enter the appropriate code for co-payment exceptions on claims submitted for outpatient services. (To be used in conjunction with FL 14, Type of Admission). 1 Physician referral 2 Clinic referral 4 Transfer from a hospital 5 Transfer from a skilled nursing facility (SNF) 6 Transfer from another health care facility 8 Court/Law Enforcement 9 Information not available E Transfer from an Ambulatory Surgery Center F Transfer from a Hospice Agency **Newborns** 5 Baby born inside this hospital 6 Baby born outside this hospital
16. Discharge Hour	2 digits	Not Required
17. Patient Discharge Status	2 digits	Conditional Enter member status as of discharge date. 01 Discharged to Home or Self Care (Dialysis is limited to code 01) 02 Discharged/transferred to another short term hospital 03 Discharged/transferred to a Skilled Nursing Facility (SNF) 04 Discharged/transferred to an Intermediate Care Facility (ICF) 05 Discharged/transferred to another type institution 06 Discharged/transferred to home under care of organized Home and Community Based Services Program (HCBS)

Form Locator and Label	Completion Format	Instructions
		07 Left against medical advice or discontinued care 08 Discharged/transferred to home under care of a Home Health provider 09 Admitted as an inpatient to this hospital 20 Expired 30** Still a member or expected to return for outpatient services 31** Still a member - Awaiting transfer to long term psychiatric hospital 32** Still a Member - Awaiting placement by Health First Colorado 50 Hospice – Home 51 Hospice - Medical Facility 61 Discharged/transferred within this institution to hospital based Medicare approved swing bed 62 Discharged/transferred to an inpatient rehabilitation hospital. 63 Discharged/transferred to a Medicare certified long term care hospital. 65 Discharge/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital 66 Transferred/Discharged to Critical Access Hospital CAH 70 Discharged/Transferred to Other HC Institution 71 Discharged/transferred/referred to another institution for outpatient services 72 Discharged/transferred/referred to this institution for outpatient services Use code 02 for a PPS hospital transferring a member to another PPS hospital. Code 05, Discharged to Another Type Institution, is the most appropriate code to use for a PPS hospital transferring a member to an exempt hospital. **A PPS hospital cannot use Member Status codes 30, 31 or 32 on any claim submitted for DRG reimbursement. The code(s) are valid for use on exempt hospital claims only.

Form Locator and Label	Completion Format	Instructions
		Interim bills may be submitted for Prospective Payment System (PPS) -DRG claims, but must meet specific billing requirements. For exempt hospitals use the appropriate code from the codes listed. Note: Refer to the "Interim" billing instruction in this section of the manual.
18-28. Condition Codes	2 Digits	Conditional Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing. **Condition Codes** 01 Military service related 02 Employment related 04 HMO enrollee 05 Lien has been filed 06 ESRD member - First 18 months entitlement 07 Treatment of non-terminal condition/hospice member 17 Member is homeless 25 Member is a non-US resident 39 Private room medically necessary 42 Outpatient Continued Care not related to Inpatient 44 Inpatient CHANGED TO Outpatient 51 Outpatient Non-diagnostic Service unrelated to Inpatient admit 60 DRG (Day outlier) **Renal dialysis settings** 71 Full care unit 72 Self care unit 73 Self care training 74 Home care 75 Home care - 100 percent reimbursement 76 Back-up facility **Special Program Indicator Codes** A1 EPSDT/CHAP A2 Physically Handicapped Children's Program A4 Family Planning A6 PPV/Medicare

Form Locator and Label	Completion Format	Instructions
		A9 Second Opinion Surgery AA Abortion Due to Rape AB Abortion Done Due to Incest AD Abortion Due to Life Endangerment AI Sterilization B3 Pregnancy Indicator B4 Admission Unrelated to Discharge **PRO Approval Codes** C1 Approved as billed C2 Automatic approval as billed - Based on focused review C3 Partial approval C4 Admission/Services denied C5 Post payment review applicable C6 Admission preauthorization C7 Extended authorization
29. Accident State		Optional
31-34. Occurrence Code/Date	2 digits and 6 digits	Conditional Complete both the code and date of occurrence. Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format. **Occurrence Codes:** 01 Accident/Medical Coverage 02 Auto Accident - No Fault Liability 03 Accident/Tort Liability 04 Accident/Employment Related 05 Other Accident/No Medical Coverage or Liability Coverage 06 Crime Victim 20 Date Guarantee of Payment Began 24* Date Insurance Denied 25* Date Benefits Terminated by Primary Payer 26 Date Skilled Nursing Facility Bed Available 27 Date of Hospice Certification or Re-certification 40 Scheduled Date of Admission (RTD)

Form Locator and Label	Completion Format	Instructions
		50 Medicare Pay Date 51 Medicare Denial Date 55 Insurance Pay Date A3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer A indicated in FL 50 B3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer B indicated in FL 50 C3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer C indicated in FL 50 **Other Payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third party information.*
35-36. Occurrence Span Code From/ Through	2 digits and 6 digits	Leave blank
38. Responsible Party Name/ Address	None	Not required Submitted information is not entered into the claim processing system.
39-41. Value Code-Code Value Code-Amount	2 characters and 9 digits	Conditional Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim. Never enter negative amounts. If a value code is entered, a dollar amount or numeric value related to the code **must** always be entered. 01 Most common semiprivate rate (Accommodation Rate) 06 Medicare blood deductible 14 No fault including auto/other 15 Worker's Compensation 30 Preadmission testing 31 Member Liability Amount 32 Multiple Member Ambulance Transport 37 Pints of Blood Furnished

Form Locator and Label	Completion Format	Instructions
		38 Blood Deductible Pints 40 New Coverage Not Implemented by HMO 45 Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour). 49 Hematocrit Reading - EPO Related 58 Arterial Blood Gas (PO2/PA2) 68 EPO-Drug 80 Covered Days 81 Non-Covered Days Enter the deductible amount applied by indicated payer: A1 Deductible Payer A B1 Deductible Payer B C1 Deductible Payer C Enter the amount applied to member's co-insurance by indicated payer: A2 Coinsurance Payer A B2 Coinsurance Payer B C2 Coinsurance Payer C Enter the amount paid by indicated payer: A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C Enter the amount paid by member FC Member Paid Amount For Rancho Coma Score bill with appropriate diagnosis for head injury. Medicare & TPL - See A1-A3, B1-B3, & C1-C3 above
42. Revenue Code	3 digits	Required Enter the revenue code which identifies the specific accommodation or ancillary service provided. List revenue codes in ascending order. A revenue code must appear only once per date of service. If more than one of the same service is provided on the same day, combine the units and charges on one line accordingly. When billing outpatient hospital radiology, the radiology revenue code may be repeated, but the corresponding

Form Locator and Label	Completion Format	Instructions
		HCPCS code cannot be repeated for the same date of service. Refer to instructions under FL 44 (HCPCS/Rates). Psychiatric step down Use the following revenue codes: 114 Psychiatric Step Down 1 124 Psychiatric Step Down 2
43. Revenue Code Description	Text	Required Enter the revenue code description or abbreviated description.
44. HCPCS/Rates /HIPPS Rate Codes	5 digits	Conditional Enter only the HCPCS code for each detail line. Use approved modifiers listed in this section for hospital based transportation services. Complete for laboratory, radiology, physical therapy, occupational therapy, and hospital based transportation. When billing HCPCS codes, the appropriate revenue code must also be billed. HCPCS codes must be identified for the following revenue codes: ▪ 30X LABORATORY ▪ 32X RADIOLOGY – DIAGNOSTIC ▪ 33X RADIOLOGY – THERAPEUTIC ▪ 34X NUCLEAR MEDICINE ▪ 35X CT SCAN ▪ 40X OTHER IMAGING SERVICES ▪ 42X PHYSICAL THERAPY ▪ 43X OCCUPATIONAL THERAPY ▪ 44X SPEECH THERAPY ▪ 54X AMBULANCE ▪ 61X MRI HCPCS codes cannot be repeated for the same date of service. Combine the units in FL 46 (Service Units) to report multiple services. The following revenue codes always require a HCPCS code. Please reference the Bulletins web page for a list of physician-administered drugs that also require an NDC code. When a HCPCS code is repeated more than once per day and billed on separate lines, use modifier 76 to indicate this is a repeat procedure and not a duplicate.

Form Locator and Label	Completion Format	Instructions
		0252 Non-Generic Drugs 0253 Take Home Drugs 0255 Drugs Incident to Radiology 0257 Non-Prescription 0258 IV Solutions 0259 Other Pharmacy 0260 IV Therapy General Classification 0261 Infusion Pump 0262 IV Therapy/Pharmacy Services 0263 IV Therapy/Drug/Supply Delivery 0264 IV Therapy/Supplies 0269 Other IV Therapy 0631 Single Source Drug 0632 Multiple Source Drug 0633 Restrictive Prescription 0634 Erythropoietin (EPO) <10,000 0635 Erythropoietin (EPO) >10,000 0636 Drugs Requiring Detailed Coding
45. Service Date	6 digits	Required For span bills only Enter the date of service using MMDDYY format for each detail line completed. Each date of service must fall within the date span entered in the "Statement Covers Period" (FL 6). Not required for single date of service claims.
46. Service Units	3 digits	Required Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit) The grand total line (Line 23) does not require a unit value. For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in FL 45.
47. Total Charges	9 digits	Required Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party

Form Locator and Label	Completion Format	Instructions
		payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges.
48. Non-Covered Charges	9 digits	Conditional Enter incurred charges that are not payable by Health First Colorado. Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges). Each column requires a grand total. Non-covered charges cannot be billed for outpatient hospital laboratory or hospital based transportation services.
50. Payer Name	1 letter and text	Required Enter the payment source code followed by name of each payer organization from which the provider might expect payment. At least one line must indicate Health First Colorado. Source Payment Codes B Workmen's Compensation C Medicare D Health First Colorado E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer
51. Health Plan ID	8 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the eight-digit Health First Colorado provider number assigned to the **billing provider**. Payment is made to the enrolled provider or agency that is assigned this number.

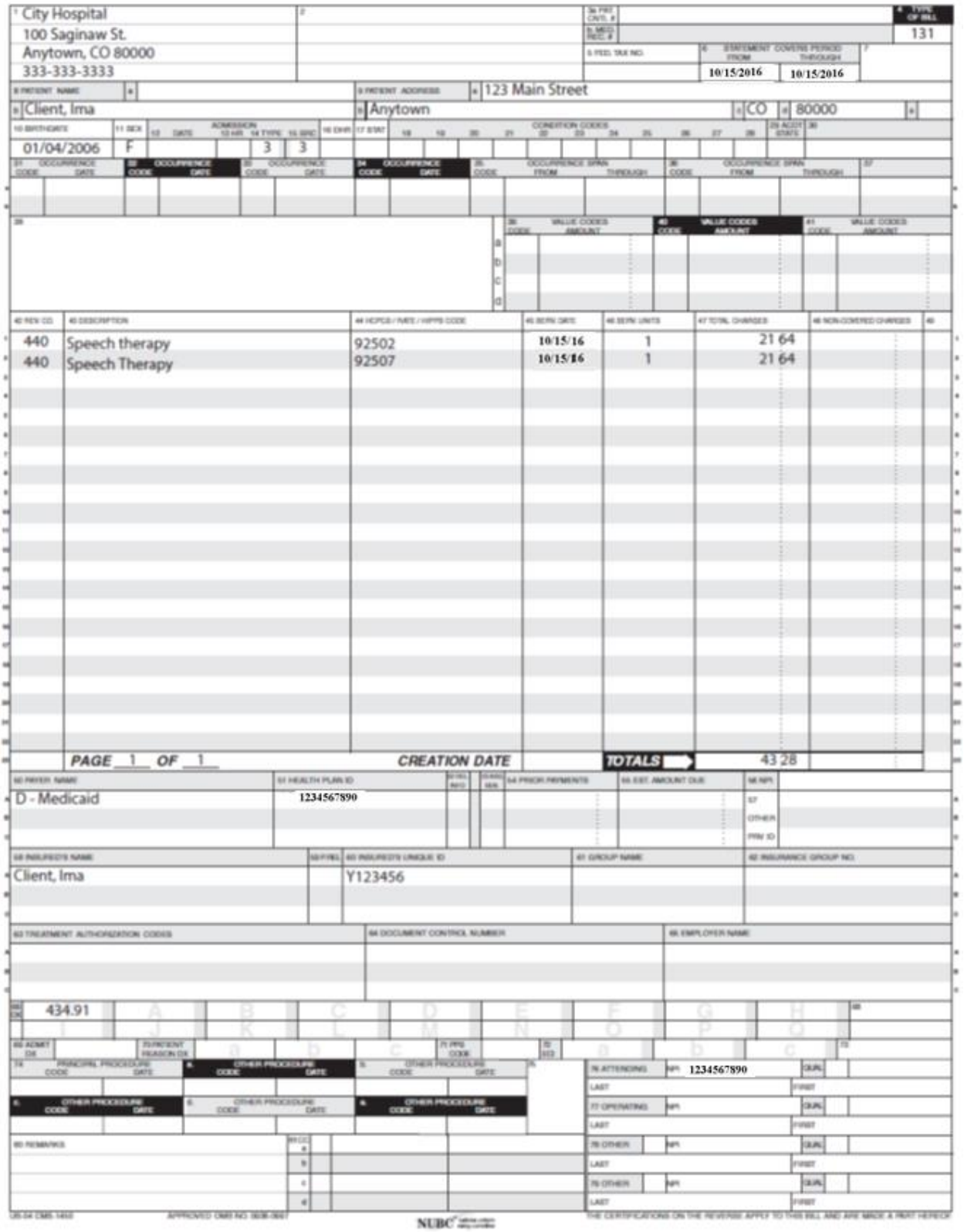
Form Locator and Label		Completion Format	Instructions
52.	**Release of Information**		Not required Submitted information is not entered into the claim processing system.
53.	**Assignment of Benefits**		Not required Submitted information is not entered into the claim processing system.
54.	**Prior Payments**	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.
55.	**Estimated Amount Due**	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter the net amount due from Health First Colorado after provider has received other third party, Medicare or member liability amount. **Medicare Crossovers** Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and member payments.
56.	**National Provider Identifier (NPI)**	10 digits	Optional Enter the billing provider's 10-digit National Provider Identifier (NPI).
57.	**Other Provider ID**		Not required Submitted information is not entered into the claim processing system.
58.	**Insured's Name**	Up to 30 characters	Required Enter the member's name on the Health First Colorado line. **Other Insurance/Medicare** Complete additional lines when there is third party coverage. =Enter the policyholder's last name, first name, and middle initial.
60.	**Insured's Unique ID**	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the health insurance card. Include letter prefixes or suffixes shown on the card.

Form Locator and Label	Completion Format	Instructions
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the authorization number in this FL if a PAR is required and has been approved for services.
64. Document Control Number		Conditional
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Not required Submitted information is not entered into the claim processing system.
67. Principal Diagnosis Code	Up to 6 digits	Required Enter the exact diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.
67A- 67Q. Other Diagnosis	Up to 6 digits	Conditional Enter the exact diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code.

Form Locator and Label	Completion Format	Instructions
69. Admitting Diagnosis Code	Up to 6 digits	Optional Enter the diagnosis code as stated by the physician at the time of admission.
70. Patient Reason Diagnosis		Not required Submitted information is not entered into the claim processing system.
71. PPS Code		Not required Submitted information is not entered into the claim processing system.
72. External Cause of Injury Code (E-code)	Up to 6 digits	Optional Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E."
74. Principal Procedure Code/ Date	Up to 7 characters or Up to 6 digits	Conditional Enter the procedure code for the principal procedure performed during this billing period and the date on which procedure was performed. Enter the date using MMDDYY format. Apply the following criteria to determine the principle procedure: The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment; and The principal procedure is most related to the primary diagnosis.
74A. Other Procedure Code/Date	Up to 7 characters or Up to 6 digits	Conditional Complete when there are additional significant procedure codes. Enter the procedure codes identifying all significant procedures other than the principle procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principle diagnosis. Enter the date using MMDDYY format.
76. Attending **NPI – Conditional** **QUAL - Conditional**	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits	Health First Colorado ID Required NPI - Enter the 10-digit NPI number assigned to the physician having primary responsibility for the member's medical care and treatment. This number is obtained from the physician, and **cannot** be a clinic or group number.

Form Locator and Label	Completion Format	Instructions
ID - (Health First Colorado Provider #) – Required **Attending- Last/ First Name**	Text	(If the attending physician is not enrolled in Health First Colorado or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.) Hospitals may enter the member's regular physician's 10-digit NPI in the Attending Physician ID form locator if the locum tenens physician is not enrolled in Health First Colorado. QUAL – Enter "1D" for Medicaid Enter the attending physician's last and first name. This form locator must be completed for all services.
77. Operating- NPI/QUAL/ID		Not required Submitted information is not entered into the claim processing system.
78-79. Other ID **NPI – Conditional** **QUAL - Conditional** **ID - (Health First Colorado Provider #) – Conditional**	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits	Conditional – Complete when attending physician is not the PCP or to identify additional physicians. NPI - Enter up to two 10-digit NPI numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the PCP or if a clinic is a PCP agent, enter the PCP NPI number as the referring physician. The name of the Health First Colorado member's PCP appears on the eligibility verification. Review either for eligibility and PCP. Health First Colorado does not require that the PCP number appear more than once on each claim submitted. The attending physician's last and first name are optional.
80. Remarks	Text	Optional Enter specific additional information necessary to process the claim or fulfill reporting requirements.
81. Code-Code QUAL/CODE/VALUE (a-d)		Optional Submitted information is not entered into the claim processing system.

UB-04 Outpatient Speech Therapy Claim Example



440	Speech therapy	92502	10/15/16	1	21 64	
440	Speech Therapy	92507	10/15/16	1	21 64	
	PAGE 1 OF 1	CREATION DATE		TOTALS	43 28	

1 City Hospital
100 Saginaw St.
Anytown, CO 80000
333-333-3333

4 TYPE OF BILL: 131
6 STATEMENT COVERS PERIOD: FROM 10/15/2016 THROUGH 10/15/2016

8 PATIENT NAME: a b Client, Ima
9 PATIENT ADDRESS: a 123 Main Street b Anytown c CO d 80000

10 BIRTHDATE: 01/04/2006
11 SEX: F
14 TYPE: 3
15 SRC: 3

42 REV CD: 440 440
43 DESCRIPTION: Speech therapy; Speech Therapy
44 HCPCS / RATE / HIPPS CODE: 92502; 92507
45 SERV DATE: 10/15/16; 10/15/16
46 SERV UNITS: 1; 1
47 TOTAL CHARGES: 21 64; 21 64
48 NON-COVERED CHARGES:

50 PAYER NAME: D - Medicaid
51 HEALTH PLAN ID: 1234567890

58 INSURED'S NAME: Client, Ima
60 INSURED'S UNIQUE ID: Y123456

66 ADMIT DX: 434.91

76 ATTENDING NPI: 1234567890

80 REMARKS:

NUBC

Institutional Provider Certification

The Institutional Certification form is available on the Department's website, on the Provider Forms web page under the "Claim Forms and Attachments" drop-down.

Timely Filing

For more information on timely filing policy, including the resubmission rules for denied claims, please see the General Provider Information manual.

Speech Therapy Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016, please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*Multiple*	*HPE (now DXC)*
1/10/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_4.xlsx*	*Multiple*	*HPE (now DXC)*
1/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE (now DXC)*
3/7/2017	*Clarified billing for assistants, clinical fellows. Clarified PAR documentation requirements. Updated eligibility message for HPE response.*	*Multiple*	*AW*
5/26/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*11*	*DXC*
8/22/2017	*Organizational updates, clarification on CCBs as referring providers for IFSP early intervention services*	*Multiple*	*AW*
1/15/2018	*Organizational updates, inclusion of documentation policy, incorporation of policy from the Speech-language and Hearing Services Benefit Coverage Standard. Revision of coding table for 2018 HCPCS changes.* *Updated page numbering system so that document page number matched the actual page number.*	*Multiple*	*AW*
02/22/2018	*Removed NDC supplemental qualifier - not relevant for speech therapy providers*	*52*	*DXC*
06/15/2018	*Updated timely filing information and removed references to LBOD; removed general billing information already available in the General Provider Information manual*	*20-22, 50, 61*	*DXC*
10/19/2018	*Updated coding table. Code descriptions removed. Providers must reference coding resources for full descriptions.*	*17*	*AW*

Revision Date	***Additions/Changes***	***Pages***	***Made by***
12/20/2018	*Clarification to signature requirements*	*23, 29*	*HCPF*
1/24/2019	*Updated visit note documentation requirements to require SOAP format, updated procedure code table with current PAR status, updated Prior Authorization Requirements section. Updated NCCI reference language to match current NCCI manual revision 2019.*	*8, 16, 17, 18*	*HCPF*
1/25/19	*Added link to Provider Forms for Institutional Provider certification*	*51*	*HCPF*

***Note**: In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above are the page numbers on which the updates/changes occur.*